PHYSICIAN REIMBURSEMENT UNDER MEDICARE: OPTIONS FOR CHANGE

The Congress of the United States
Congressional Budget Office

NOTES

Unless otherwise indicated, all years referred to in this report are calendar years.

Details in the text and tables of this report may not add to totals because of rounding.

Estimates and projections incorporate all legislation enacted as of April 15, 1986 (including the Consolidated Omnibus Budget Reconciliation Act of 1985).

PREFACE

Federal spending per enrollee under Medicare continues to increase at more than twice the rate of economywide inflation. Many factors account for this growth, including aging of the Medicare population, medical advances that expand the services physicians can provide, and poor incentives for physicians to use health care resources prudently. This study, conducted by the Congressional Budget Office (CBO) at the request of Senator Lawton Chiles for the Senate Budget Committee, examines options for changing Medicare's primary method of reimbursing physicians with a view toward achieving better cost containment. In accordance with CBO's mandate to provide objective analysis, this report offers no recommendations.

The study was done by Sandra Christensen of CBO's Human Resources Division, under the general direction of Nancy Gordon and Stephen Long. Roald Euller, also of the Human Resources Division, did the programming required for the data analysis presented in Appendix B. CBO projections presented in the report were made by Diane Burnside of the Budget Analysis Division.

Many others contributed to the study. Jack Hadley and Janet Mitchell were consultants for the study and made numerous helpful suggestions, as did Paul Ginsburg, Peter McMenamin, Louis Rossiter, and Ralph Smith. In addition, useful comments on review drafts were received from Roger Herdman and Jane Sisk at the Office of Technology Assessment, from James Cantwell at the General Accounting Office, and from Jennifer O'Sullivan and James Reuter at the Congressional Research Service. A number of people in the Department of Health and Human Services helped, but especially Ira Burney, Allen Dobson, John Drabek, George Greenberg, Stephen Jencks, William Sobaski, Earl Swartz, Sherry Terrell, and Barbara Wynn. Dr. John Ball assisted by providing the physician's perspective.

Norma Leake helped to verify that tables were accurate. The paper was edited by Sherry Snyder, assisted by Nancy Brooks. Jill Bury prepared the manuscript for publication.

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GLOSSARY

AAPCC	The adjusted average per capita cost of treating Medicare enrollees in the fee-for-service sector, which is used to establish Medicare's capitation payments to prepaid medical plans.
ACR	The adjusted community rate, which is the estimated per capita cost to a prepaid medical plan for providing services covered by Medicare to Medicare enrollees.
CPR	The customary, prevailing, and reasonable system by which Medicare sets payment rates for physicians' services.
CPT-4	The Common Procedural Terminology system (4th ed.) developed by the American Medical Association to describe physicians' services.
DRGs	Diagnosis-related groups, which are used to classify Medicare hospital inpatients to determine payment rates under the prospective payment system.
GDP	Gross domestic product, a measure of domestic production whether the income goes to domestic or foreign residents.
GNP	Gross national product, a measure of domestic income, including income produced abroad and excluding income produced domestically but sent abroad.
HCFA	The Health Care Financing Administration in the Department of Health and Human Services.
HCPCS	HCFA's Common Procedure Coding System used to describe the services billed to Medicare under the Supplementary Medical Insurance program.
HI	The Hospital Insurance program--Part A of Medicare--which pays facility fees for care provided in hospitals, skilled nursing facilities, hospices, and for some home care.

HMO	A health maintenance organization, which is a form of prepaid medical plan in which the physicians who provide services are paid on some basis other than fee-for-service.
IPA	An independent practice association, which is a form of prepaid medical plan in which physicians who provide services are paid on a fee-for-service basis.
MEI	The Medicare Economic Index--an economywide index of earnings and office practice expenses used to limit growth in Medicare's prevailing fees.
PMP	A prepaid medical plan, which provides all covered services to enrollees in return for a fixed per capita payment.
PPO	A preferred provider organization, which is a consortium of physicians and other providers of health care who have agreed with an insurer to treat its enrollees at negotiated (generally discounted) prices.
PPS	The prospective payment system used for Medicare's reimbursement to hospitals.
PROs	Peer Review Organizations, established in each state to monitor both hospital admissions and the quality of care provided to Medicare enrollees.
RAPs	Radiologists, anesthesiologists, and pathologists--supporting physicians whose services are often hospital-based.
RVS	A relative value scale, which gives each medical service a weight to indicate its value relative to any other service.
SMI	The Supplementary Medical Insurance program--Part B of Medicare--which pays for physicians' services, facility fees in hospital outpatient departments and ambulatory surgicenters, and charges by independent laboratories and other medical suppliers.
UCR	The usual, customary, and reasonable system--similar to Medicare's CPR system--that is used by some private insurers to set payment rates.

SUMMARY

Total Medicare reimbursements per enrollee increased at an annual rate of 13.6 percent from 1975 through 1985, more than twice the rate of economywide inflation (see Summary Table 1). Reimbursements per enrollee for Part B of Medicare--the Supplementary Medical Insurance (SMI) program, which pays for physicians' services--increased even more rapidly, at an annual rate of 15.5 percent.

Concern over the alarming rate of growth in costs has led the Congress to reconsider Medicare's methods for reimbursing health care providers, since these methods were not designed to encourage cost-conscious behavior. Historically, hospitals were reimbursed for whatever costs they incurred, giving them little incentive to seek more cost-effective ways of providing care. Physicians were paid on the basis of their customary charges (subject to a limit set by fees prevailing in the community) for whatever services they provided. As a result, they had few incentives either to restrain fee increases or to limit the volume of services provided to their patients.

In fiscal year 1984, Medicare's retrospective cost-based reimbursement system for hospital inpatient care was replaced by the prospective payment system (PPS). Under the PPS, hospitals are paid a fixed amount per admission, based on each patient's diagnosis at the time of discharge. Since (with minor exceptions) the hospital's reimbursement is the same regardless of the services provided to the patient, hospitals have financial incentives to reduce both the patient's length of stay and hospital services provided during the stay, within the limits of acceptable medical practice. Further, they have incentives to deliver services cost-effectively. On the other hand, the PPS also generates incentives for hospitals to increase admissions if possible, and to prefer to admit patients with less severe conditions for a given diagnosis over patients whose care may be more costly.

No significant change in the way Medicare reimburses physicians for their services has been made since 1972, when a cost-based index was introduced to limit growth in payment rates. In 1984, however, the Congress

froze Medicare's payment rates to physicians until October 1985. This was later extended until May 1, 1986, for physicians who signed "participating" agreements, thereby agreeing to accept Medicare's payment rates for all their Medicare patients. For other physicians, the freeze was extended until January 1, 1987.

A freeze is only a temporary measure, however, while fundamental changes for physician reimbursement are developed. Fee constraints are often not effective at containing costs unless accompanied by controls on

SUMMARY TABLE 1. MEDICARE REIMBURSEMENTS AND ANNUAL RATES OF GROWTH, 1975-1985

	Reimbursements (millions of dollars)		Annual Rate of Growth
	1975	1985	1975-1985
Hospital Insurance			
Total Reimbursements	11,315	47,579	15.4
Per Enrollee	470	1,572	12.8
In Constant (1985) Dollars a/	884	1,572	5.9
Supplementary Medical Insurance			
Total Reimbursements	4,273	22,947	18.3
Per Enrollee	181	766	15.5
In Constant (1985) Dollars a/	340	766	8.4
Total Medicare			
Total Reimbursements	15,588	70,526	16.3
Per Enrollee	650	2,337	13.6
In Constant (1985) Dollars a/	1,225	2,337	6.7

SOURCE: Congressional Budget Office from data provided by the Health Care Financing Administration.

a. The gross national product (GNP) deflator was used to obtain constant dollars.

use of services, because physicians may respond to fee constraints by providing more services to their patients. In addition, if fee constraints increase the gap between Medicare's payment rates and the higher rates of other payers, Medicare enrollees might find it more difficult to locate physicians willing to treat them. Further, across-the-board freezes are inequitable for physicians whose fees were already relatively low.

In order to examine more fundamental changes in Medicare's methods for paying physicians, the Congress authorized the creation of a Physician Payment Review Commission in the Consolidated Omnibus Budget Reconciliation Act of 1985. The ongoing duties of this commission (if funded) are to make recommendations to the Congress and to the Secretary of the Department of Health and Human Services concerning Medicare's mechanisms for paying physicians. This study by the Congressional Budget Office (CBO) contributes to the analysis of alternative payment systems.

MEDICARE'S PRIMARY METHOD OF REIMBURSING PHYSICIANS

Under the customary, prevailing, and reasonable (CPR) system by which Medicare currently sets payment rates for physicians in the fee-for-service sector, payment for each service provided is the lowest of the physician's actual charge, the physician's customary charge for that service, or the prevailing fee for that service in the community. Prevailing fees are based on the customary charges of all physicians in the community, but increases in prevailing fees above their values for 1973 are limited by an index of earnings and office practice expenses that is called the Medicare Economic Index (MEI).

Dissatisfaction with the CPR system is widespread, primarily because of the poor incentives it creates for physicians. Specific objections cited are that it:

- Induces inflation in fees;
- Encourages growth in the volume (either the number or the average complexity) of services; and
- Distorts physicians' decisions in other undesirable ways.

The CPR system encourages fee inflation because of the automatic link between physicians' actual charges and Medicare's payment rates, which are based on the previous year's actual charges through the customary and